FLEXIBLE FUNDS POLICY AND PROCEDURE

In this document, CCC is referenced in place of CCC and CHA.

CONTENTS

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Terms not defined in the DEFINITIONS section of this document may be found in our Glossary.

1 PURPOSE

1.1 This policy and procedure establishes guidelines for expenditures defined as “flexible services”, which aim to provide goods and services that support the well-being of members which are not covered benefits.

2 SCOPE

2.1 This policy defines resources available to members to support necessary care. Flexible Services are considered in the context of the member’s overall integrated care planning and management by the primary care team, including the member’s CHA case manager, behavioral and oral health providers.

3 POLICY STATEMENT

3.1 Flexible Services may be used to support member treatment plans to assist in improving overall member health and wellness. To be eligible, the Oregon Health Plan (OHP) member must have at three months of continuous enrollment with medical coverage through Cascade Health Alliance (CHA) and be currently enrolled when a request is made. Exception is made for pregnancy and neonates. Individuals reviewing the application are responsible for verifying member eligibility status with Medicaid Management Information System (MMIS) and/or Essette. Services requested must be consistent with the member’s treatment plan as developed by the member’s primary care team.

3.1.1 Treatment plans are developed in the member’s preferred language and responsive to the member’s cultural needs.

3.2 Documentation must be included in the clinical record describing how the services requested are appropriate and needed to achieve the treatment goals. Documentation must be current within the last 6 months of request.

3.3 Services may include coordinated intervention planning with community agencies/partners but may not duplicate services that are provided through any other community agency.

3.4 Flex funds are designated to meet the unique needs of an individual member. If the flex fund expense is not addressing a unique need, it is not an appropriate use of flex funds.

3.5 Flexible Funds are only to be used after all other sources of funding have been exhausted.

3.6 Flex funds may not be used purely for diversional or recreational activities or items.

3.7 Flex funds are limited to eligible members; members must be eligible on the date of the request per MMIS.

3.8 Flex services expenditures must be documented with receipts and a brief statement of the therapeutic purpose of the expense.

3.9 Payments for flex fund services/goods are made directly to the vendor by CHA.

3.10 Flex funds must be time limited per the member's care/treatment plan and cost-efficient.

3.11 Flex funds are limited to $250.00 per member per calendar year.

3.12 Flex service funds are reported and categorized per Oregon Health Authority (OHA) criteria.

4 PROCEDURE

Process

4.1 Provider must submit a completed *Flex Fund Request Form PP06008.01* to the Case Management (CM) Department. Forms are accepted by fax or mail.

4.2 Routine requests are reviewed and processed within 14 calendar days by the CM Department. Approval of Flex Funds is noted in the request and in member's Essette PM chart. If member is open to Case Management, the CM is notified and approval is noted in CM chart notes under category heading "Flexible Funds".

4.3 Denial of Flex Fund request requires the review of a Case Manager and may be sent to the Chief Medical Officer (CMO) for second level review. The CM Department must notify the provider and member of the decision.

4.4 Denial of Flex Funds is noted in the request and in member's Essette PM chart. If member is open to Case Management, the CM is notified and denial is noted in CM chart notes under category heading "Flexible Funds".

4.5 No appeal or reconsideration rights are allowed under the Flex Fund policy.

4.6 Members are notified by telephone when an item is ready for pickup; items are available for 30 calendar days after notification. If items are not picked up during that time, items are returned to stock. Alternately, items may be ordered and shipped directly to member's home. Flex Fund staff will attempt to reach member by phone or mail to verify shipping address. If member cannot be reach after at least 4 attempts in a 30 day period, the Flex Fund will be cancelled and item not ordered.

4.7 CHA staff will work with member's PCP/clinic to obtain current, viable contact information as needed.

Tracking

4.8 The Case Assistant must document the number of items being dispensed, the type of item, and the cost of the item in Essette in the Flex Fund request document.

4.9 A Flex service log is maintained, per contract year, to track the cost of goods and/or services provided by the Flex Funds. A separate line/row for each payment of service is made. Each log must include, at a minimum:

4.9.1 Member ID

4.9.2 Date of service

4.9.3 Health condition to be improved

4.9.4 Name of provider or payee for the service or goods

4.9.5 The applicable Flexible Service category (new categories cannot be added):

4.9.5.1 Health improvement

4.9.5.2 Medical supplies

4.9.5.3 Home safety needs

4.9.5.4 Food and oral supplements

4.9.6 The applicable Rationale for the Flexible Service

4.9.7 How the effectiveness of the goods and/or services are measured and demonstrated

4.9.8 Cost

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 The Flex service log is compiled and stored in the Case Management shared folder on the secure network.

5.2 The Executive Approval Committee will review this policy for compliance with OHA contract and guidelines at least once a year, or as applicable.

Reporting

5.3 Flexible services are recorded within Exhibit L and submitted to the state as specified by OHA. The amount reported is the total expenditure for all flexible services provided to members during the reporting period.

5.3.1 Exhibit L Financial Reporting Template can be found at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx

Records Management

5.4 Team Members must maintain all records relevant to administering this policy and procedure in our record management system.

6 DEFINITIONS

Terms and Definitions

6.1 **Flexible Services:** Health-related, non-State Plan services intended to improve health outcomes, care delivery, prevent and/or delay health deterioration and lower cost. Flexible Services are considered in the context of the member's overall integrated care planning and management by the primary care team, including the member's behavioral and oral health. Flexible Services are often unable to be reported in the conventional manner using Current Procedural Terminology (CPT) or Healthcare Common Procedural Coding System (HCPCS) codes, and can effectively treat the physical or mental healthcare condition documented in the Member's health or clinical record Services must be consistent with member's treatment plan as developed by the primary care team and documented in the clinical record. Services must be cost effective alternatives to cover benefits and likely to generate a savings. Flexible Services may include, but are not limited to:

6.1.1 Purchased good and/or services necessary to meet the identified needs to member/family as part of the treatment plan

6.1.2 Non-prescription nutritional items of services (e.g. training in health food preparation)

6.1.3 Educational services, both group and individual

7 RELATED LEGISLATION AND DOCUMENTS

7.1 OHA: Coordinated Care Organizations (CCO)

7.2 OHA Exhibit L Financial Reporting Template

8 FEEDBACK

8.1 Team Members may provide feedback about this document by emailing policyfeedback@cascadecomp.com.

9 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Executive Approval Committee
Committee Review Dates	10/09/2018, 10/17/2019
Approval Dates	10/23/2019

10 APPENDICES

10.1 APPENDIX 1: *Flex Fund Request Form PP06008.01*

10.2 APPENDIX 2: *Flex Fund Dispense Form PP06008.03*